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AUTHOR Sommers, Paul A.
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ABSTRACT

The paper describes a medical-educational model which systematically integrates services and follow-up activity in a standard manner for exceptional children, particularly the mentally retarded. The report reviews model elements and shares experiences with an emphasis on stimulating other health care service groups to consider standardizing medical-educational services. (Author/SBH)

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STANDARDIZING MEDICAL-EDUCATIONAL SERVICES FOR EXCEPTIONAL CHILDREN: A FOCUS ON MENTAL RETARDATION

by:

Paul A. Sommers, Ph.D.
Director: Liaison Education Affairs
Comprehensive Child Care Center
Marshfield Clinic and Medical Foundation
1000 North Oak Avenue
Marshfield, Wisconsin 54449
Tel. AC (715) 387-5228

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ABSTRACT

Recent Federal and State trends (implementation of PL94-142 and similar state mandates) have reflected movements which tend to standardize the delivery of educational services to all areas of exceptionality. Children who are mentally retarded have in the past been somewhat singled out as a group of exceptional children, who because of limited intellectual ability should not be expected to develop appropriate social graces, learn school related academics, pre-vocational skills nor be able to make essential adjustments into the world of work. Although larger than once believed, the number of mentally retarded children necessitating medical services for appropriate program development warrants simultaneous concern and handling from medical service providers. We know that mentally retarded children can produce appropriate learning and vocationally related results. However, it becomes necessary to treat this individual as any other child with exceptional needs (i.e. learning disabled, visually impaired, hearing impaired, etc.); develop learning/vocational expectancies based upon individual abilities and needs; and, provide supportive services (i.e. medical, psychological, counselling, etc.) in a standard format to promote a meld of efficiency and effectiveness in the service delivery process. A medical-educational model has been in existence since July 1975 which systematically integrates services and follow-up activity in a standard manner for all exceptional children. This report will review model elements and share experiences with an emphasis on stimulating other health care service groups to consider standardizing medical-educational services.

Medicine and education may have joint responsibilities for children who have exceptional health and/or educational needs (Sommers & Nycz, 1978). It is incumbent upon both educators and clinical staff to understand each others referral procedures; diagnosis and assessment activities; treatment and educational intervention programs; "least restrictive" alternatives; and, follow-up plans for exceptional children. Although, basically different philosophical, administrative and service structures are in existence within each discipline, a natural bridge is formed when the focus of service is upon the exceptional child. Many variables must be considered in the development of a medical-educational service model and range from: legal, financial and administrative-to-appropriate communications, understanding, and patience. However, the fact remains that the job of providing comprehensive service must get done and as soon as possible (hopefully at the same time the exceptional need is identified).

Children who are mentally retarded have been singled out among the exceptionalities more because of their static intellectual abilities than anything else (Sommers, 1977). It appears that the condition of 'mental retardation' represents an irreversible situation which permeates throughout all facets of the childs' development into adulthood. Social learning, in addition to the more objectively defined areas, i.e. academics, general curricular offerings, vocational skill acquisition and occupational adjustment, etc. seem to reflect stereotyped expectations for the mentally retarded. Perhaps through a re-establishment of proposed individuality as indicated in PL94-142 (Handicapped Childrens Act of 1975) each child will be afforded 'equal educational opportunity to maximize their optimum potential' regardless of handicapping condition. Labels used for purposes of classification and educational placement must be cast aside

since each mentally retarded child necessitates programming and resource services based upon their individualized learning needs - not to be predicated upon a label of mental retardation which has proven to be a 'stigma' of the most self-limiting variety (Rosenthal & Jacobson, 1968; Goffman, 1961; Kitsuse & Cicourel, 1963; and, Paul, 1969).

MEDICAL IMPLICATIONS

Public education now has a standard direction through PL94-142 to provide individualized educational services to exceptional children. This imputes should help to alleviate past inequities dealt the mentally retarded, since multidisciplinary teams are to develop their plans and individualized education plans (I.E.P.'s) for each identified child in a uniform manner without regard to 'a label'. The health care services, however, do not have a legislative act upon which to build their cadre of essential services. The role of physicians' in PL94-142 is implied rather than defined although the existence of coordinated medical services for the handicapped is not new (Allen & Lelchuck, 1966).

Clinics and medical centers who provide services to handicapped children must be aware of any educational needs, as well as: local school resources, available expertise and support services to be utilized in following through with services "back home" after the clinic visit. It is essential for health care providers to actively seek assistance from educators, social service personnel, public health nurses, parents and other individuals, agencies and organizations who work on a daily basis with children who have been sent for diagnosis and treatment.

COMMUNICATIONS

Educators must make their needs known to medical staff serving children from their schools, and, medical service providers must provide

information illustrating the nature of available services and how these services can be routinely initiated for children who have exceptional health and/or educational needs. It is incumbent upon educators to clearly spell out the questions they would like answered for each child being sent for clinical service. It is most appropriate for educators to "write-out", in advance of the clinic visit, all pertinent questions or to attend staffings to discuss the implications.

Medical staff in turn should consider procedures to insure, that after the clinic visit appropriate follow-up activities are implemented. These activities should include an integrated summary report of all medical findings and a clear picture of how the findings relate to the education of the child.

A MEDICAL AND EDUCATIONAL APPROACH

A medical-educational service model has been developed and implemented for children with exceptional health and/or educational needs through the Comprehensive Child Care Center of the Marshfield Clinic (Sommers & Nycz, 1978; Sommers, Jones, Griese & Theye, 1978). The Center operates in a "supportive role" for exceptional children in public and private schools, developmental disability programs and residential treatment facilities. The program began in July 1975 and has served children from throughout the State of Wisconsin and the Upper Peninsula of Michigan. Health care services emanate through the Marshfield Clinic in Marshfield, Wisconsin which is the sixth largest medical group practice in the U.S.A.

Organizational Elements

The provision of comprehensive evaluation, diagnosis, treatment and needed follow-up services for children (from birth through age 21) with exceptional health and/or educational needs is the basic purpose of the

Comprehensive Child Care Center. Referral procedures have been established and are initiated by contacting the patient coordinator by telephone, in person or by letter. Those conditions which would most likely necessitate a referral include a: physical, crippling or orthopedic disability; hearing disability; visual disability; developmental disability or mental retardation; learning difficulty; speech or language disability; behavioral or emotional problem; seizures; gifted or talented characteristics; and, generally any condition that is suspected of developing into an exceptional health and/or educational need.

Anyone may make a referral of a child to the Center. Most often referring are administrators, parents, teachers, physicians, social workers, psychologists, county, state, and other agencies. If after evaluation by the medical staff, the child is found to have a problem, appropriate follow-up procedures based upon parent consent may warrant contacting other agencies and organizations concerned about the child. A patient coordinator has been assigned to handle all aspects of case processing after a child has been referred. Contact is made with the parents or legal guardian if other than the parent(s) made the referral. Medical, educational and developmental history forms are then sent to parents for completion. Records are also collected from schools or other program center(s) working with child. All necessary appointments are scheduled on the same day if at all possible. After the child has been evaluated, a primary physician or clinician will have a conference with the parents and program staff from child's home community (if available) to summarize the findings. Liaison education is also available to provide an interface of medical and educational data for intervention and programming purposes. Table 1 illustrates the patient flow through procedure beginning with referral.

(INSERT TABLE 1 ABOUT HERE)

Table 1

An Overview Of The Patient Flow Through Procedure Beginning With Referral Of Child

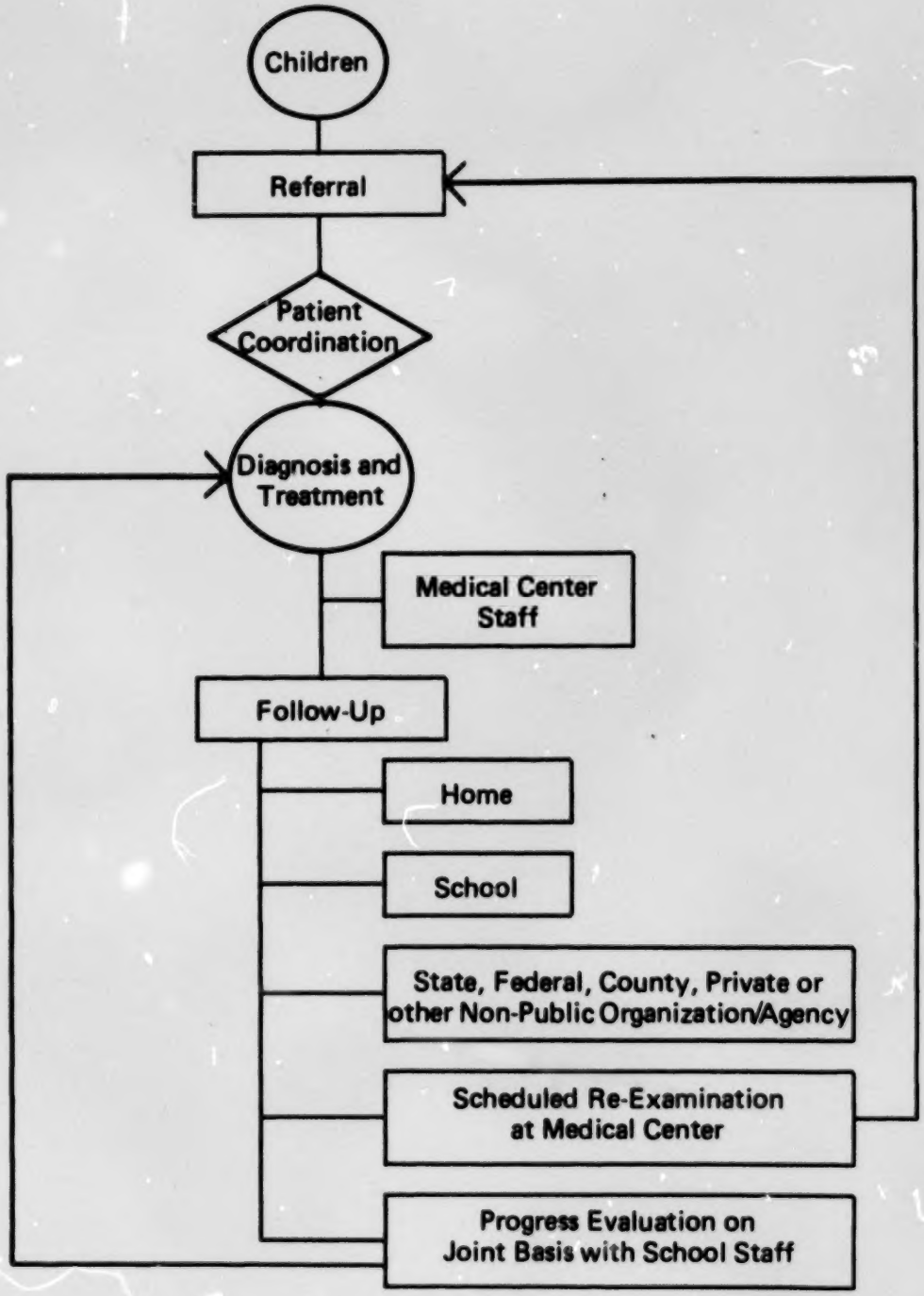

Table 1

Medical-Educational Interaction
for Exceptional Children

P. A. Sommers, Ph.D.

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Integration of Services

A necessary step is the integration of medical and educational services. Table 2 illustrates a medical-educational approach for diagnostic purposes. Table 3 shows the relationship of treatment and intervention services.

The overall operation of a medical-educational service system is reflected in Table 4 which indicates the basic patient flow procedure with consideration given to referral, diagnostic, and treatment/intervention considerations. Evaluation is seen as an essential element and is defined as information obtained through analysis of the progress being made by each child. This data becomes available at the treatment and intervention level.

(INSERT TABLES 2, 3 and 4 ABOUT HERE)

RESULTS

Children who are mentally retarded have been effectively integrated into a medical-educational system to serve all exceptional children in a comprehensive manner. By establishing a routine procedure to identify, treat, program and follow-up on each exceptional child's needs, a focus has been maintained on their individualized medical and learning attributes and not 'labels'.

The service provided those exceptional children served by this approach has been assessed via specifically developed parent and case-coordinator evaluation questionnaires. Case coordinators are individuals in the childs' home community who refer children for medical services or coordinate their learning and other related day activities outside the jurisdiction of the home.

Services provided to 274 children from July 1, 1975 to July 1, 1977 have been analyzed to determine (1) how satisfied consumers (i.e. parents and case coordinators) have been with the medical-educational approach;

Table 2

Medical-Educational Interaction for Diagnostic Services

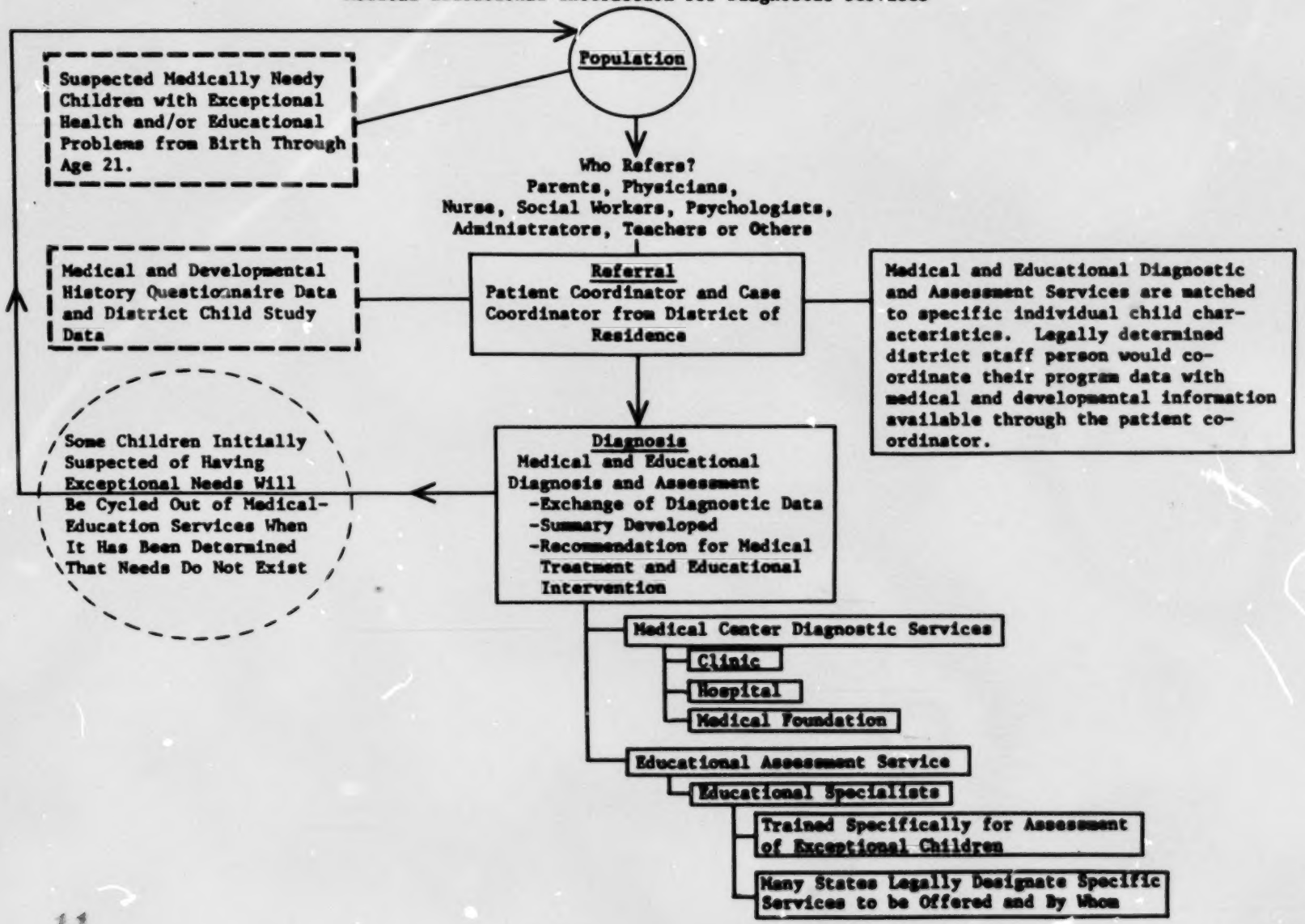
Population
Suspected Medically Needy Children with Exceptional Health and/or Educational Problems from Birth Through Age 21.
Who Refers?
Parents, Physicians, Nurse, Social Workers, Psychologists, Administrators, Teachers or Others
Referral
Patient Coordinator and Case Coordinator from District of Residence
Medical and Developmental History Questionnaire Data and District Child Study Data
Medical and Educational Diagnostic and Assessment Services are matched to specific individual child characteristics. Legally determined district staff person would coordinate their program data with medical and developmental information available through the patient coordinator.
Diagnosis
Medical and Educational Diagnosis and Assessment
-Exchange of Diagnostic Data
-Summary Developed
-Recommendation for Medical Treatment and Educational Intervention
Some Children Initially Suspected of Having Exceptional Needs Will Be Cycled Out of Medical-Education Services When It Has Been Determined That Needs Do Not Exist
Medical Center Diagnostic Services
Clinic
Hospital
Medical Foundation
Educational Assessment Service
Educational Specialists
Trained Specifically for Assessment of Exceptional Children
Many States Legally Designate Specific Services to be Offered and By Whom

Table 2

Medical-Educational Interaction
for Exceptional Children

P. A. Sommers, Ph.D.

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Table 3

Medical-Educational Interaction for Treatment and Intervention Services

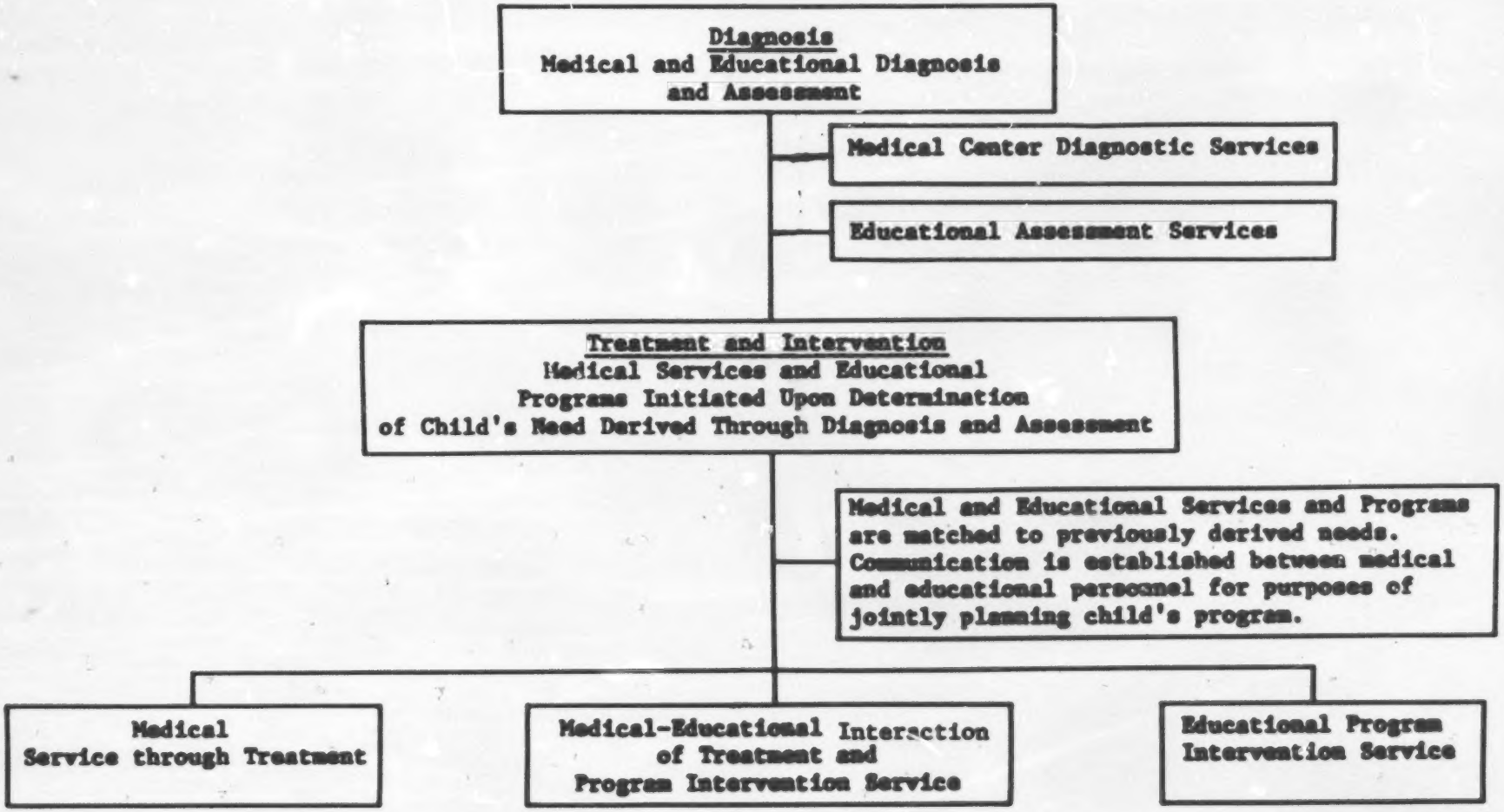
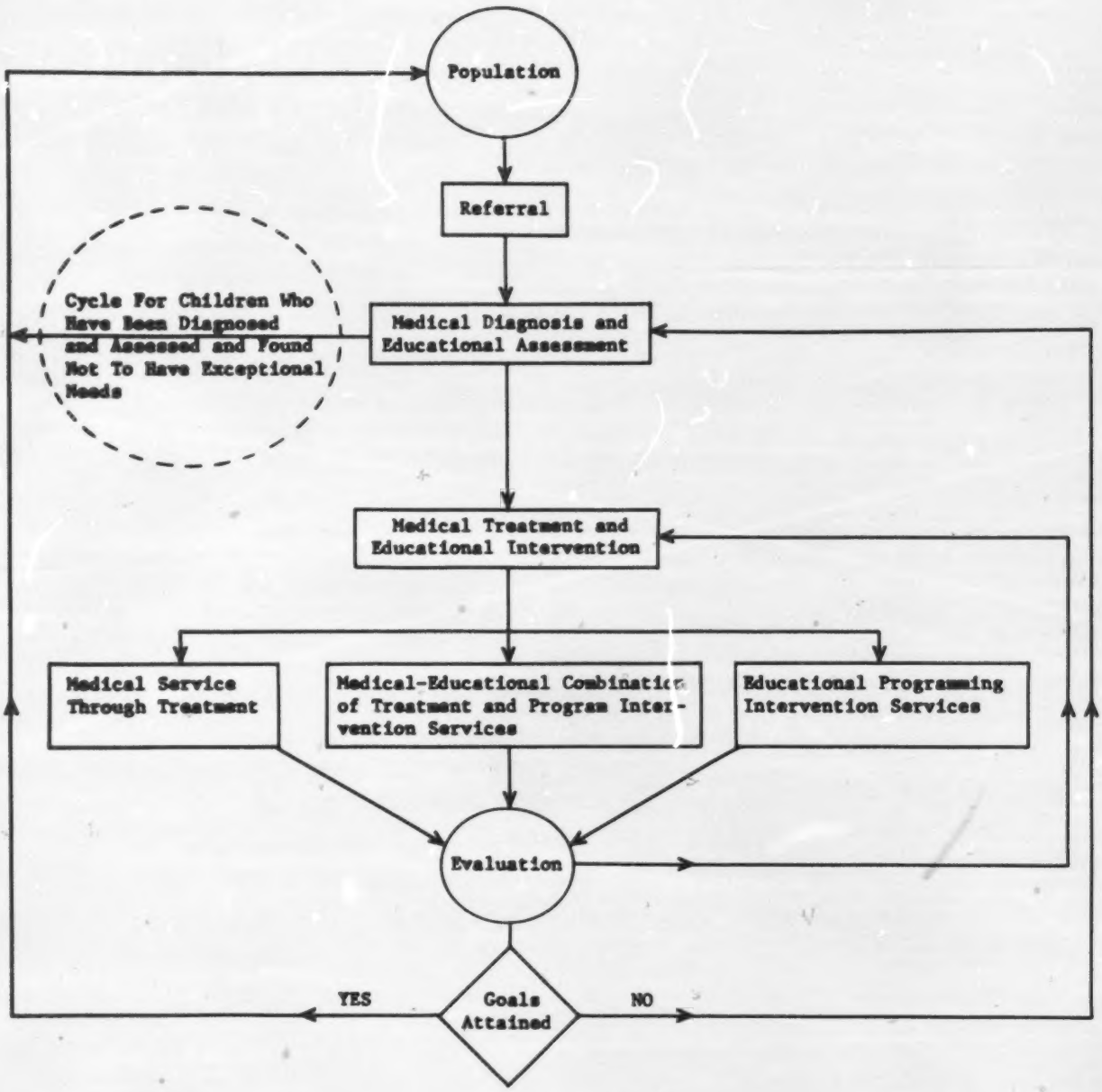

Diagnosis
Medical and Educational Diagnosis and Assessment
Medical Center Diagnostic Services
Educational Assessment Services
Treatment and Intervention
Medical Services and Educational Programs Initiated Upon Determination of Child's Need Derived Through Diagnosis and Assessment
Medical and Educational Services and Programs are matched to previously derived needs. Communication is established between medical and educational personnel for purposes of jointly planning child's program.
Medical Service through Treatment
Medical-Educational Interaction of Treatment and Program Intervention Service
Educational Program Intervention Service

Table 4

A Medical-Educational Interaction System


Population
Referral
Cycle For Children Who Have Been Diagnosed and Assessed and Found Not To Have Exceptional Needs
Medical Diagnosis and Educational Assessment
Medical Treatment and Educational Intervention
Medical Service Through Treatment
Medical-Educational Combinatio of Treatment and Program Inter-vention Services
Educational Programming Intervention Services
Evaluation
YES
Goals Attained
NO

and, (2) if there has been a significant difference in the evaluation ratings of the two groups for similar children on the subject of overall satisfaction with services.

Longitudinally, it has been found that both consumer groups are satisfied with a comprehensive medical-educational approach for exceptional children. In addition, the consumer input received has been used to modify and improve the service delivery system by reflecting those program elements in need of change. A paired associates t-test examination was made to determine the discrepancy of opinion between parents and case coordinators for the question: "Were you pleased with the overall service provided by the Comprehensive Child Care Center?" A significant difference at the probability level of .05 has been noted for children provided service during 1975-1976 ($N=64$, $\bar{D}=10.63$, $^{S}D=28.78$, $t=2.95$, $df=63.00$) and during 1976-1977 ($N=58$, $\bar{D}=8.88$, $^{S}D=32.32$, $t=2.09$, $df=57$)‡. This result suggests a need to more fully explore both respondent groups to determine commonalities and further refine procedures to better meet their expectations.

SUMMARY

The stigmatizing effects associated with mental retardation have for too long prevented children from actualizing their fullest potential. In part, medicine has been a contributing element by sustaining the overwhelming interpretation that the condition of 'mental retardation' represents an irreversible situation caused by static intellectual development. A model has been suggested in this report to comprehensively serve all exceptional children through a multispecialty medical-educational

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‡ Further details available on request to author.

approach with a focus on dynamic care planning and follow-up without regard to labels. The Comprehensive Child Care Center model has proven successful in its' meld with PL94-142, in addition to similar state legislation, i.e. Wisconsin Law - Chapter 115, and may offer other health care providers with the necessary incentive to establish a similar approach.

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